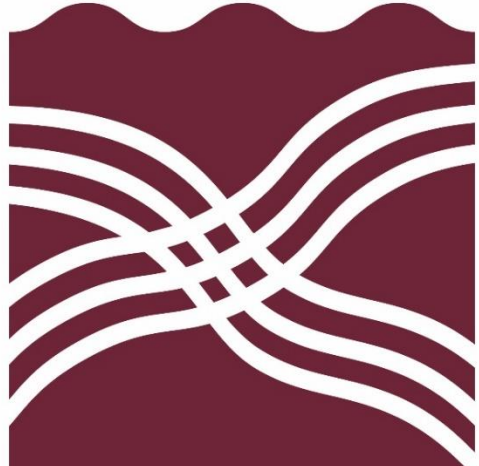




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PHC Wellness  
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# Wellness and Recovery Program

Drug Medi-Cal Organized Delivery Service  
February 2021

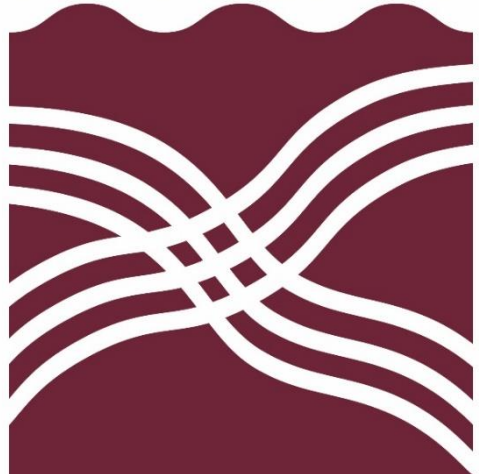
# Agenda

- Welcome and Housekeeping
- Claims
- Online Services
  - Claim Search
  - CIFs
- Contacts and Resources





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# Claims Overview Residential Services

# Overview

- Types of Covered Services
- Modifiers, Procedure Codes, ICD-10 & Place of Service Codes
- Billable Modifiers
- Billable Procedure Codes
- HCPCS & Modifier Guide for levels of care
- HCPCS, Modifier & Place of Service Code Examples
- Group Formula
- Same Day Services
- Claim Corrections/CIFs
- Important Information
- Resources



# CMS-1500 Billing Form

PICA CARRIER

**HEALTH INSURANCE CLAIM FORM**  
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE (Medicare #)		2. MEDICAID (Medicaid #)		3. TRICARE (ICW/DOO#)		4. CHAMPVA (Member ID#)		5. GROUP (Group #)		6. FECA (IC#)		7. OTHER (IC#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)											
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE (MM DD YY)		SEX (M F)		4. INSURED'S NAME (Last Name, First Name, Middle Initial)		5. PATIENT RELATIONSHIP TO INSURED (Self Spouse Child Other)		6. RESERVED FOR NUCC USE		7. INSURED'S ADDRESS (No., Street)		8. CITY STATE											
5. PATIENT'S ADDRESS (No., Street)		6. RESERVED FOR NUCC USE		7. INSURED'S ADDRESS (No., Street)		8. CITY STATE		9. ZIP CODE		10. TELEPHONE (Include Area Code)		11. ZIP CODE		12. YES (Include Area Code)											
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY NUMBER OR FECA NUMBER		12. IS THERE ANOTHER HEALTH BENEFIT PLAN?		13. IS THERE ANOTHER HEALTH BENEFIT PLAN? (If yes, complete items 9, 10 and 11)		14. IS THERE ANOTHER HEALTH BENEFIT PLAN? (If yes, complete items 9, 10 and 11)		15. IS THERE ANOTHER HEALTH BENEFIT PLAN? (If yes, complete items 9, 10 and 11)		16. IS THERE ANOTHER HEALTH BENEFIT PLAN? (If yes, complete items 9, 10 and 11)											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		13. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		14. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		15. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		17. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		18. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		19. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)		20. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.)									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP)		15. OTHER DATE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM TO)		17. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (FROM TO)		18. OUTSIDE LAB? \$ CHARGES		19. YES NO		20. RESUBMISSION CODE ORIGINAL REF. NO.		21. PRIOR AUTHORIZATION NUMBER											
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a. QUAL.		17b. NPI		22. RESUBMISSION CODE ORIGINAL REF. NO.		23. PRIOR AUTHORIZATION NUMBER		24. A. DATES OF SERVICE (From To)		24. B. PLACE OF SERVICE (EMG)		24. C. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS MODIFIER)		24. D. DIAGNOSIS POINTER		24. E. \$ CHARGES		24. F. DAPS USE		24. G. H. I. J. RENDERING PROVIDER ID #			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate ALL to service the below (4RE) ICD 10)		A. F15.20		B.		C.		D.		E.		F.		G.		H.		I.		J.					
24. A. DATES OF SERVICE (From To)		24. B. PLACE OF SERVICE (EMG)		24. C. PROCEDURES, SERVICES, OR SUPPLIES (CPT/HCPCS MODIFIER)		24. D. DIAGNOSIS POINTER		24. E. \$ CHARGES		24. F. DAPS USE		24. G. H. I. J. RENDERING PROVIDER ID #		25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For 90% rate, see 1500)		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$	
25. FEDERAL TAX I.D. NUMBER		26. PATIENT'S ACCOUNT NO.		27. ACCEPT ASSIGNMENT? (For 90% rate, see 1500)		28. TOTAL CHARGE \$		29. AMOUNT PAID \$		30. BALANCE DUE \$		31. SIGNATURE OF PHYSICIAN OR SUPPLIER (Including degrees or credentials (I certify that the statements on the reverse apply to this bill and are made a part thereof.))		32. SERVICE FACILITY LOCATION INFORMATION		33. BILLING PROVIDER INFO & PH # ( )		34. SIGNATURE		35. DATE		36. SIGNATURE		37. DATE	

# Types of Covered Services

All Medi-Cal beneficiaries in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties who meet medical necessity criteria can access the full continuum of substance use treatment services to include:

- Outpatient Services (ASAM Level 1)
- Intensive Outpatient Services (ASAM Level 2.1)
- Residential Services (ASAM Levels 3.1 & 3.5) up to 90 days
- Withdrawal Management (“Detox”)
- Recovery Services (Community Support)
- Opioid (Narcotic) Treatment Program Services

# Billing Codes

**Modifiers:** Modifiers are a 2 digit code used to supplement a procedure code. Wellness and Recovery modifiers are used to distinguish different levels of care.

**Procedure Codes:** Procedure Codes are a medical code set used to report medical, surgical and diagnostic procedures and services. CPT codes are a numeric 5 digit code. HCPCS codes are an alpha numeric 5 digit code.

The Wellness and Recovery Program uses HCPCS codes.

**ICD-10:** ICD-10 codes are alpha numeric codes used to report a patients diagnosis.

**Place of Service Codes:** These codes are used to specify the entity where services were rendered. Wellness and Recovery will include Place of Service Codes such as:

55 - Residential

57- Non-Residential

11 - Office

02 - Telehealth

14 - Group Home

20 – Urgent Care

**Note:** This is not an all-inclusive list

# Billable Modifiers

Modifier	Definition	Description
U1	ASAM 3.1 Residential	Medicaid level of care 1
U3	ASAM 3.5 Residential	Medicaid level of care 3
U6	ODS Recovery Services	Medicaid level of care 6
U9	ODS ASAM 3.2 Withdrawal Management	Medicaid level of care 9
HA	Under 21 years old	Child/adolescent program
HD	Perinatal Services	Pregnant/parenting women's program

CMS1500 example:

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	
From			To			PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER
02	01	20	02	07	20	55		H0019	U3



# Billable Procedure Codes

Procedure	Description
<b>G9008</b>	<b>Physician Consultation</b> – Coordinated care fee, physician coordinated care oversight services, <b>per minute.</b>
<b>H0004</b>	<b>Individual Counseling</b> – Behavioral health counseling and therapy, <b>per minute.</b>
<b>H0005</b>	<b>Group Counseling</b> – Alcohol and/or drug services; group counseling by a clinician, <b>per minute.</b>
<b>H0006</b>	<b>Case Management</b> – Alcohol and/or drug services, <b>per minute.</b>
<b>H0012</b>	<b>Residential Withdrawal Management</b> – Alcohol and/or drug services; sub-acute detoxification (residential addiction program outpatient), <b>per bed day.</b>
<b>H0019</b>	<b>Residential</b> – TAR required, Up to 90 days, <b>per bed day.</b>
<b>T1012</b>	<b>Recovery Services</b> – Recovery Monitoring/Substance Abuse Assistance, <b>per minute.</b>

CMS1500 example:

24. A. DATE(S) OF SERVICE						B.	C.	D.PROCEDURES, SERVICES, OR SUPPLIES	
From			To			PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER
02	01	20	02	07	20	55		H0019	U3

# ASAM 3.1 Residential

3.1 Residential		1st Modifier	2nd Modifier
H0019	Residential	U1	
H0006	Case Management	U1	
G9008	Physician Consultation	U1	
H0004	Recovery Services-Individual Counseling	U6	U1
H0005	Recovery Services-Group Counseling	U6	U1
H0006	Recovery Services-Case Management	U6	U1
T1012	Recovery Services-Recovery Monitoring/Substance Abuse Assistance	U6	U1

CMS1500 example:

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)			
From		To				CPT/HCPCS	MODIFIER				
MM	DD	YY	MM	DD	YY						
02	01	20	02	07	20	55		H0019	U3		

# ASAM 3.5 Residential

3.5 Residential		1st Modifier	2nd Modifier
H0019	Residential	U3	
H0006	Case Management	U3	
G9008	Physician Consultation	U3	
H0004	Recovery Services-Individual Counseling	U6	U3
H0005	Recovery Services-Group Counseling	U6	U3
H0006	Recovery Services-Case Management	U6	U3
T1012	Recovery Services-Recovery Monitoring/Substance Abuse Assistance	U6	U3

CMS1500 example:

24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)	
From			To					CPT/HCPCS	MODIFIER
MM	DD	YY	MM	DD	YY				
02	01	20	02	07	20	55		H0019	U3



# ODS ASAM 3.2 Withdrawal Management

ODS 3.2 WM		1 <sup>st</sup> Modifier	2 <sup>nd</sup> Modifier
H0012	Residential Withdrawal Management	U9	
H0006	Case Management	U9	
G9008	Physician Consultation	U9	

CMS1500 example:

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES	
From		To				PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)	
MM	DD	YY	MM	DD	YY			CPT/HCPCS	MODIFIER
01	01	20	01	01	20	55		H0012	U9

# Group Formula

## Procedure Code H0005 (Group Counseling)

### Group services should use the following methodology:

- Number of minutes for the group + travel/number of beneficiaries in the group = Total minutes per beneficiary + documentation time

### To bill for transportation, the counselor must document in progress notes:

- Date
- Start and end time to the service location
- Start and end time back to the facility

Documentation time is specific to the beneficiary and the time it takes for the counselor to write a progress note for each beneficiary that participated in the group.

Example: Document the date, start and end time - 4/02/19, 1 p.m. to 1:05 p.m.

**Note:** If a member leaves a group counseling session prior to the completion (Ex: if one person out of that group was only there for 30 minutes of the 1 hour group session), you will need to remove the member from the group formula.

# Group Formula Example

## Example:

15 minutes transportation to site + 90 minute group + 15 minutes transportation back to the facility site

= 120 minutes/number of beneficiaries in group (10)

= 12 minutes per beneficiary

+ 5 minutes for documentation time

**17 minutes**

This claim can be billed with 17 units for each individual who participated in the group which you will indicate in box 24 "G" on the CMS-1500

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES				E.	F.		G.
From		To				PLACE OF SERVICE	EMG	(Explain Unusual Circumstances)		CPT/HCPCS	MODIFIER	DIAGNOSIS POINTER	\$ CHARGES		DAYS OR UNITS
MM	DD	YY	MM	DD	YY										
Grp formula ex: 30 mileage + 90 group ÷ 10 (# in grp) = 12 + 5 min documentation = 17															
03	01	20	03	01	20	57		H0005	U7			A	50.00	00	17



# Same-Day Services

Beneficiaries are eligible to receive more than one service per day by various providers

This is to ensure correct level of care placement for beneficiaries

Many services are allowed to be billed in the same day when the combination of services does not have a conflict

## **Note:**

- If the Member receives multiple services of the *same code and date of service*, by different rendering provider (counselors), the distinctive NPI needs to be billed individually on separate lines.
- If the Member receives multiple services of the *same code and date of service*, by the same rendering provider (counselor), the services should combine into one claim line.

Please refer to the MHSUDS Information Notice 17-039 for more information related to same-day services. This notice can be found on the DHCS website.

# Important Information

- There must be a CalOMS Episode for each member prior to billing.
- All claims must be submitted within 90 days from the date of service.
- Claims must be submitted in the same month, claims cannot cross months. i.e. Dates of service 02/01/2021-03/05/2021 must be billed on 2 separate claims:
  - 1<sup>st</sup> claim 02/01/2021-02/28/2021
  - 2<sup>nd</sup> claim 03/01/2021-03/05/2021
- All Residential bed days require a TAR – specific to procedure H0019

# Billing Code Examples

**The use of the “U” Modifier codes are to distinguish different levels of care. You must have both a procedure code and a Modifier for each line billed.**

## Examples:

Non-perinatal adolescent beneficiary is served in a level 3.5 residential facility and there is a physician consultation that needs to be claimed, the codes and modifiers would be – G9008|U3|HA with Place of Service 55

Perinatal adult receiving case management in a residential program (3.1) H0006|U1|HD with Place of Service 55

Residential bed day (3.5) for adult beneficiary - H0019|U3 with Place of Service 55

Residential bed day (3.5) for perinatal adolescent beneficiary – H0019|U3|HD|HA with Place of Service 55

Perinatal adult beneficiary in Residential Withdrawal Management H0012|U9|HD with Place of Service 55



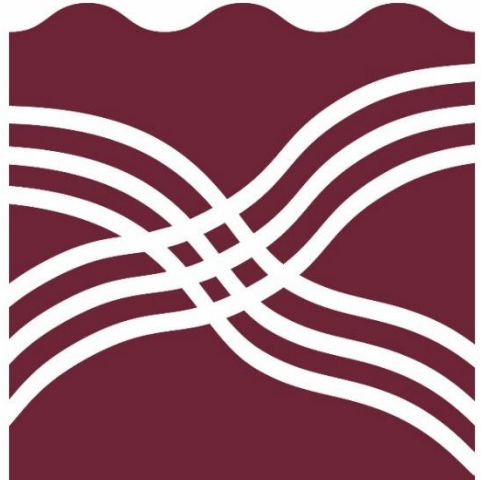
# Laboratory Services

Laboratory Services are not separately reimbursable for Wellness & Recovery

**Note: Solano County members only:** Solano County PHC members must use a Quest service center. Providers must coordinate with Quest Diagnostics for specimen pickup if lab draw done at provider site.



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# Provider Online Services Claims

## **Claim Search Module**

Lets users search for claims and view detailed information.

## **Check Search Module**

Lets users search for checks and view check details.

## **EOP Remittance Module**

Provides details on the Explanation of Payments and claims that have been paid, denied, or adjusted.

## **Claims Inquiry Form (CIF)**

Lets users search for claims and submit corrections (add or change) information.



# Claims Dashboard

From the Home Page Dashboard click the Claim Modules icon  
Select **Claim Search**

The image displays two screenshots of the PHCONLINE SERVICES dashboard. The top screenshot shows the main dashboard with three main icons: Eligibility Modules, Claim Modules (highlighted with a red box), and Clinical Modules. The bottom screenshot shows a secondary dashboard with a grid of icons: Home, Claim Search (highlighted with a red box), Check Search, EOP - Remittance Advice, PCP-AI - Remittance Advice, ACA - Remittance Advice, Claims CIF or Re-CIF Status Inquiry, and Code Lookup.

**PHCONLINE SERVICES** NORTH STATE PHYSICIANS GROUP eAdmin1

Here is the first alert

Telephone Interpretation Services

**Your eAdmin Details:**

User Name: eAdmin1  
eAdmin Name: Ed Admin  
Email: edadmin@gmail.com  
Phone Number: (530) 555-1234  
Status: Active  
[Click here to view your Provider Profiles](#)

**Your eAdmin Details:**

User Name: eAdmin21  
eAdmin Name: Addy Miner  
Email: edadmin@gmail.com  
Phone Number: (530) 555-1234  
Status: Active  
[Click here to view your Provider Profiles](#)

Eligibility Modules Claim Modules Clinical Modules


Home Claim Search Check Search

EOP - Remittance Advice PCP-AI - Remittance Advice ACA - Remittance Advice

Claims CIF or Re-CIF Status Inquiry Code Lookup

# Claim Search

**Select Provider Profiles** defaults to “all”  
Enter **Date of Service Range** and **Search Criteria**

PHC - Claim Search 

**Claim Search**

All items checked

CIN :

Last Name:

First Name:

Date of Birth:

Claim Control Number:

Date of Service Range: From  To


Date of Range:

**Search Help!**

Below is the search Criteria with the Date of Service and Date Range

- 1.CIN (for e.g.: 9999999999)
- 2.Last Name OR First Name AND Date of Birth
- 3.Claim Control Number

# Claim Search

PHC - Claim Search 

**Claim Search**

All items checked  [Select Provider Profiles](#)

CIN:

Last Name:

First Name:

Date of Birth:

Claim Control Number:

Date of Service Range: From  To

Date of Range:

**Search Help!**

Below is the search Criteria with the Date of Service and Date Range

- 1.CIN (for e.g.: 999999999)
- 2.Last Name OR First Name AND Date of Birth
- 3.Claim Control Number

Member#	Member Identifier/ CIN	Member Name	Gender	Date of Birth	Program	Actions
0008888100	12365477C6	MARY JONES	Female	7/6/1976	Medi-Cal	<input type="button" value="Select"/>

To view Claims Detail click the **Select** button below the **Actions** Tab

# Claim Summary

## Claims Summary



Back

Claim Type : M      Member Name : MARY JONES      Claim Number : 160016790012  
Date Of Service : 03/18/2016      Charge Amount : \$125.00      Date Range : 08/01/2005 to 05/16/2016

Expand All

Line#	Date	Count/Days	Proc	LC	EX	Check Number	Charge(\$)	Allow-P(\$)	Deny	Coins(\$)	SOC/ Ded(\$)	Tax(\$)	Pay(\$)	write-off(\$)	
> 0100	03/18/2016	1/0	99213	11	11	R20001099999	\$125.00	\$24.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$125.00	
							\$125.00		\$0.00					\$0.00	

Page size: 10      1 items in 1 pages

Submit CIF

### EX Codes and Descriptions

Code	Description
11	PAYABLE - CAPITATED PROCEDURE PAID AT "0"

# Claim Correction/CIFs


CIFs (Claims Inquiry Forms) are used to reconcile claim over or underpayments and resubmit corrected claims.

## CIF Timeframes:

- All CIFs, ReCIFs and Appeals must be completed within 120 days from the date of service



# Submit CIF

**Claims Summary**  [Back](#)

**Claim Type :** M      **Member Name :** Mary Jones      **Claim Number :** 160977  
**Date Of Service :** 11/18/2015      **Charge Amount :** \$310.80      **Date Range :** 08/01/2005 to 05/16/2016

[Expand All](#)

Line#	Date	Count/ Days	Proc	LC	EX	Check Number	Charge(\$)	Allow-P(\$)	Deny	Coins(\$)	SOC/ Ded(\$)	Tax(\$)	Pay(\$)	write- off(\$)
> 0100	11/18/2015	1/0	99214	11	66	R20001088	\$310.80	\$60.00	\$60.00	\$0.00	\$0.00	\$0.00	\$0.00	\$310.80
							\$310.80		\$60.00				\$0.00	

Page size: 10      1 items in 1 pages

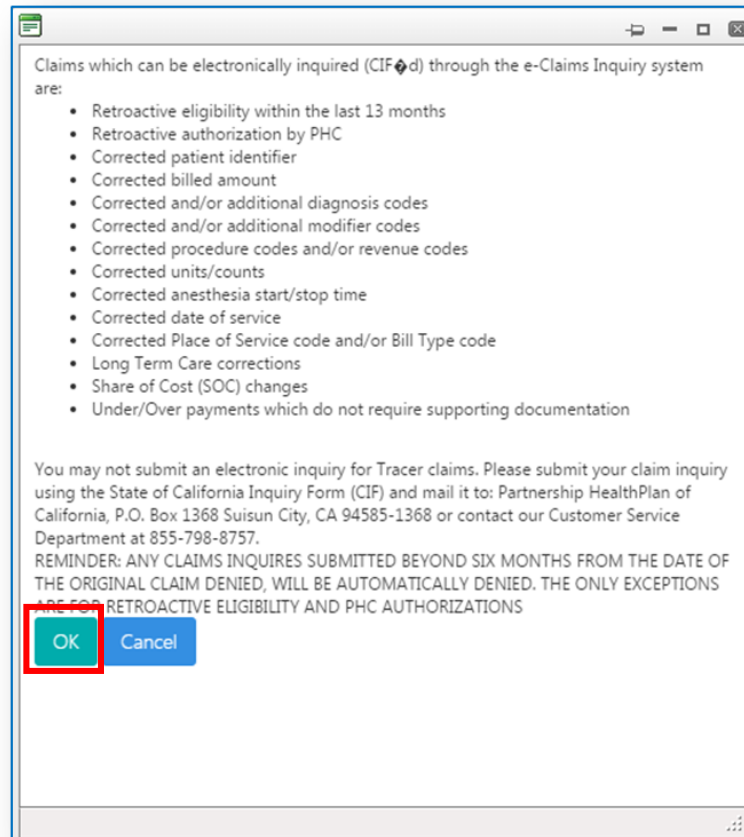
[Submit CIF](#)

**EX Codes and Descriptions**

Code	Description
66	DENIED - MEDI-CAL BENEFITS CAN'T BE PAID W/O PROOF OF MEDICARE DENIAL ←

Click **Submit CIF**

# Claims CIF or Re-CIF Status Inquiry



Review Pop-Up Window  
Click **OK** when finished

# CIF Data Screen Continued

Select Claim Type from drop down and ER or Non-ER for Box 19

## PHC - Claims Inquiry Form

### CIF Details

CIF Number:

Retro Authorization#:

Bill Type  
(UB04 Only Box 4):

CCN Number:



Claim Type:  
Type (UB04  
Only Box 19):

- Hospital Outpatient
- Physician
- Vision
- DME
- Supplies
- Home Health
- Pharmacy
- Other
- Wellness and Recovery**



### Patient Details

Medi-Cal #:

Change Medi-Cal # to:

Retroactive eligibility  
within last 13 months:

Patient Name:  
New Patient Name:

# Service Line

Line#	Date From	Date To	Proc Code(s)	LC	Charge(\$)	SOC/Ded(\$)	Pay(\$)	Counts/Units	Diagnosis	Modifiers	U+	Amount Expected	NDC Code
0100		1/28/2016	93306	22	268	0	0	1/0	R011 ..	26/,	0		

[Edit](#) [Delete](#)

**Update ServiceLine:**

Date Of Service From:

Date Of Service To:

Place of Service:

Proc. / Rev Code:

Surgical ProcCode:

Diagnosis Codes Primary:

Diagnosis Codes Secondary:

Primary Modifier:

Secondary Modifier:

NDC Codes:

Billed Amount:

Share Of Cost:

Units / Counts:

Payment Type:

+ Units:


Amount Expected:

View of data fields that can corrected.

Enter **Only** the information that **needs** to be changed.

# Action Requested

**Action Requested**

Action:  

Notify Me:


Email:

Phone:



Clicking on the arrow in the Action box opens a “drop-up” menu of items.

**Action Requested**

Action:  



Click Additional Information to open a free text box if you need to add special instructions.

- Additional Information
- Change/Add - Procedure Code/ HCPC/ REV/ Accom Code
- Change/Add - Diagnosis Code
- Change/Add - Modifier
- Change/Add - Quantity/ Count
- Change/Add - A Remark to the claim (e.g. SBMD, 911, Pre-op, Trauma)
- Change/Add - Additional Charges (e.g. add a line to the claim)
- Change/Add - Attachments (EOB/ RX/ Catalog/ Pricing)
- Change/Add - Date Change
- Change/Add - NDC
- Overpayment - Duplicate payment
- Overpayment - Take back payment
- Retro Updates to - RAF
- Retro Updates to - TAR
- Retro Updates to - SOC
- Retro Updates to - Eligibility
- Underpayment



Select the items that fit your need. You may check more than one box.

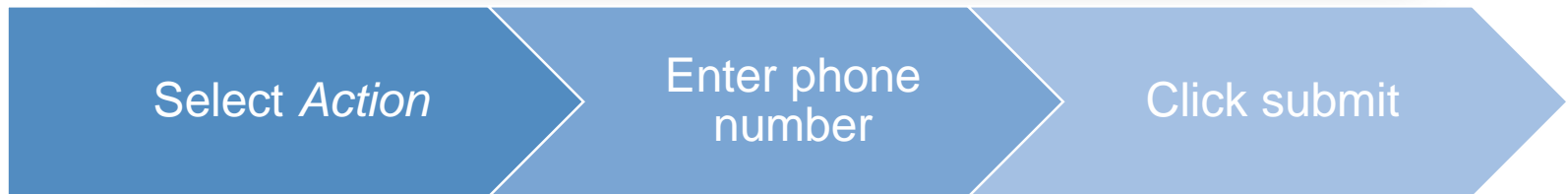


# Submit CIF

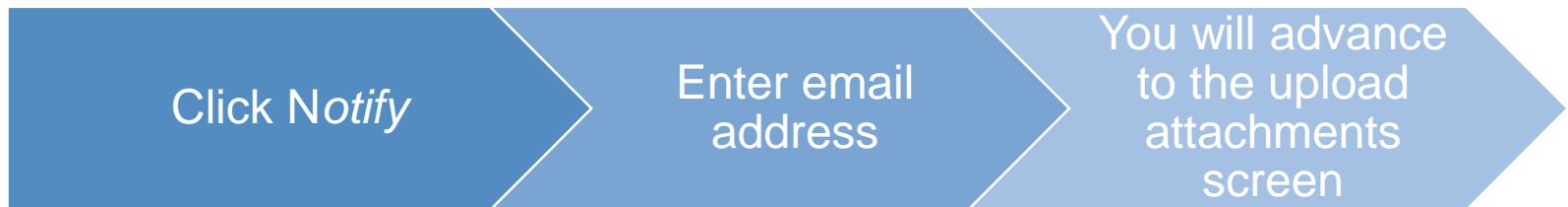
**Action Requested**

Action:   
Notify Me:   
Email:

Phone:



If you would like a completion confirmation:



# Attachments

CIF Attachments window:

PHC – Claims Inquiry Confirmation [Print](#)

---

**CIF Attachments**

CIF Number	File Name	File Type	File Size	
C160490792957	eob lookup.docx	application/vnd.openxmlformats-officedocument.wordprocessingml.document	81507	<a href="#">Delete</a> <a href="#">View</a>

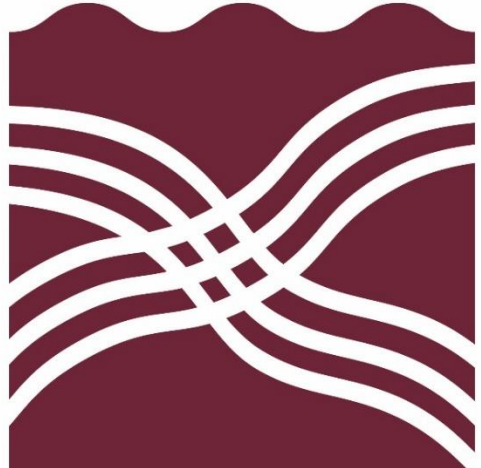
[+ Add New Attachment](#) [Refresh](#)

Click the plus (+) button to add attachment(s).

You can also delete and view your attachment(s) before sending to PHC.



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# Contacts and Resources





# Resources

Monday - Friday  
8 a.m. - 5 p.m.

Claims Support  
(530) 999-6868

Partnership HealthPlan of California  
[www.partnershiphp.org](http://www.partnershiphp.org)

Email Support

[ClaimsWellnessRecovery@partnershiphp.org](mailto:ClaimsWellnessRecovery@partnershiphp.org)

PHC Online Services

<https://provider.partnershiphp.org/IUI/Login.aspx>